STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155029		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED  D. WING 08/04/2011				
	PROVIDER OR SUPPLIE	<u> </u>	5600 E	ADDRESS, CITY, STATE, ZIP CODE 16TH ST IAPOLIS, IN 46218	3000.2000	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F0000	Complaint IN00  Complaint number Substantiated, Firelated to the all and F503  Survey dates:	per IN00093656: Federal/State deficiencies regations are cited at F502  1, 2 and 4, 2011  2000012  155029 100274900  2.N.	F0000			
		es also reflect state accordance with 410 IAC				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/04/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION 155029	X2) MULTIPLE CO A. BUILDING B. WING	00	COMPI 08/04	ETED		
NAME OF PROVIDER OR SUPPLIER  COMMUNITY NURSING AND REHABI		STREET ADDRESS, CITY, STATE, ZIP CODE  5600 E 16TH ST INDIANAPOLIS, IN 46218				
(X4) ID SUMMARY STATEMENT O PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTIF	PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE	
16.2.  Quality review completed 8/9/11 Cathy Emswiller RN		TAG				

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Event ID: 5PVS11

Facility ID: 000012

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155029		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING B. WING  (X3) DATE SURVEY  COMPLETED  08/04/2011			ETED		
	NAME OF PROVIDER OR SUPPLIER  COMMUNITY NURSING AND REHABILITATION CENTER			5600 E	DDRESS, CITY, STATE, ZIP CODE 16TH ST APOLIS, IN 46218		
(X4) ID PREFIX TAG F0502 SS=D	(EACH DEFICIEN REGULATORY OR 483.75(j)(1)	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  JIN LABORATORY	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
SS=D	PROVIDE/OBTA SVC-QUALITY/T The facility must services to meet The facility is restimeliness of the Based on record the facility failed immediately) lab be obtained and pfashion. This is with a stat order (Resident B)  Findings include  Resident B's clos reviewed on 8/1/indicated he had the facility, adm discharged to the 7/15/11 around 6 not documented) included, but were advanced cirrhos ascites and anasa hepatitis C. [As of fluid within the cavity which ofter liver disease, such is severe, general	provide or obtain laboratory the needs of its residents. ponsible for the quality and services.  review and interviews, to assure stat (needed oratory specimens would processed in a timely impacted 1 of 1 residents in the total sample of 4.  ded clinical record was 11 at 2:30 pm. It a three day admission at itted 7/12/11 p.m. and emergency room on p.m. (an exact time was it it is diagnoses in the liver with rea. He also had seites is an accumulation e peritoneal/abdominal en accompanies chronic has cirrhosis. Anasarca lized and massive edema divide with liver or heart	F050	2	F502 The facility must provide or obtain laboratory services meet the needs of its resident. The facility is responsible for the quality and timeliness of the services. What corrective action(s) will be taken for the residents found to have been affected by the deficient practice? If a physician determines that a resident requires laboratory speciment be obtained immediately, the resident will be sent to the emergency room, unless laboratory services are in the facility and can perform the necessary labs. How will you identify other residents having the potential to be affected by the same deficient practice as what corrective action will be taken? All residents who requilaboratory specimen to be obtained have the potential to affected by this alleged deficient practice. Staff Development Coordinator will educate nurse on sending a resident to the emergency room if a physician determines a laboratory specimeneds to be obtained immediately. Nursing staff will complete a pre-test and post-times.	to its.  r e e e e o to t	08/26/2011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155029	A. BUI B. WIN			08/04/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
COMMUNITY NURSING AND REHABILITATION CENTER					APOLIS, IN 46218	
(X4) ID PREFIX				ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Review of the number of the nu				CROSS-REFERENCED TO THE APPROPRIA	Ing r of ng tion ed. cly nheec. the cur, ee? lete cQI
		ports correlating with the were located within the			addressed by the CQI Committee, an action plan will put into place immediately	l be
	clinical record as	of this review.  The Director of Nursing on			pat into piaco ininiodiatory	
		.m. indicated the lab had				
		aw the blood sample				
	before Resident	B went to the hospital.				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155029	(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION 00	(X3) DATE S COMPLI <b>08/04/</b> 2	ETED		
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  5600 E 16TH ST INDIANAPOLIS, IN 46218					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
	a stat lab order, within four hours was recorded at left the facility ar four hours and for lab phlebotomist. The Director of the Director of the lab phlebotomist is located in north seems to depend staff are located order is received is drawn. The indicated there was arrangement made regarding time for the Review of the culaboratory on 8/4 indicated it did not the subject of ordests.	de with the laboratory rames for stat lab orders.  arrent contract with the l/11 at 11:50 a.m. ot specifically address ders for stat laboratory						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  OO COMPLETED				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155029		A. BUILDING 08/04/2011				
		155029	B. WING		00/04/2011	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		EET ADDRESS, CITY, STATE, ZIP CODE		
COMMUNITY NURSING AND REHABILITATION CENTER			5600 E 16TH ST INDIANAPOLIS, IN 46218			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0503 SS=D	AGREEMENT If the facility proviservices, the services, the services, the services applicable requires specified in part of the facility provisers applicable requires specified in Part.  If the laboratory of for testing to anoull aboratory must be specialties and succordance with of this chapter.  If the facility does services on site, to obtain these succordance with of this chapter.  Based on record the facility failed agreement with the regarding the time (needed immediates specimens would processed. This residents with a sumple of 4.	review and interviews, I to develop a definitive heir laboratory service he frame in which stat hetely) laboratory I be obtained and himpacted 1 of 1 hetat order in the total (Resident B)	F0503	F503 If the facility provides it own laboratory services, the series must meet the applicable requirements for laboratories specified in part 493 of this chapter. If the facility provides blood bank and transfusion series, it mu meet the applicable requirements for laboratories specified in Part 493 of this chapter. If the laboratory chooses to refer specimens testing to another laboratory the referral laboratory must be certified in the appropriate	st s for	
	reviewed on 8/1/	11 at 2:30 pm. It		certified in the appropriate		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
		IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155029	B. WIN			08/04/2011	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		_
NAME OF P	ROVIDER OR SUPPLIER				16TH ST		
COMMUNITY NURSING AND REHABILITATION CENTER					APOLIS, IN 46218		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	indicated he had	a three day admission at			specialties and subspecialtie		
	the facility, adm	itted 7/12/11 p.m. and			of services in accordance wi		
	discharged to the	e emergency room on			the requirements of part 493		
	_	p.m. (an exact time was			this chapter. If the facility do		
	not documented)	•			not provide laboratory service	es	
	·	_			on site, it must have an		
	included, but wer	· ·			agreement to obtain these	.et	
		is of the liver with			services from a laboratory the meets the applicable	aı	
	ascites and anasa	rca. He also had			requirements of part in 493 o	.f	
	hepatitis C. [As	scites is an accumulation			this chapter. What corrective		
	of fluid within th	e peritoneal/abdominal			action(s) will be taken for the		
		en accompanies chronic			residents found to have beer		
		th as cirrhosis. Anasarca			affected by the deficient		
	-				practice? The facility will obta	in a	
		lized and massive edema			definitive agreement with the		
		d with liver or heart			laboratory services regarding	the	
	failure or kidney	disease.] He was			time frame in which a laborato		
	admitted from th	e hospital and back to the			specimen will be obtained and		
	hospital.				processed. How will you		
	•				identify other residents havin	-	
	Review of the nu	rrsing notes of July			the potential to be affected b	-	
		_			the same deficient practice a		
	· · · · · · · · · · · · · · · · · · ·	cated Resident B was			what corrective action will be taken? All residents who have		
		d in 3 of 3 spheres and			laboratory order have the	; a	
	-	, eat and communicate			potential to be affected by this		
	_	on July 15th. At that			alleged deficient practice. Sta		
	time, LPN #1 do	ocumented he was "very			Development Coordinator or		
	drowsy, will resp	ond to call but will not			designee will educate nursing		
		97.7, 77, 20, 97/63, O2			staff on new agreement.		
	=	turation) 99%. Called N			Executive Director will obtain a		
					agreement with the laboratory		
	` ′	ner to report resident			service used regarding the tim	e	
	status."				frame in which a laboratory		
					specimen will be obtained and processed. What measures w		
	The Nurse Practi	tioner responded with an			be put into place or what	'III	
	order written at 1	:20 p.m. for diagnostic			systemic changes will you		
		sive metabolic panel,			make to ensure that the		
	` •	count, urinalysis with			deficient practice does not		
	complete blood t	Count, armaryoro with	1			I	

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/04/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155029		A. BUIL	DING	NSTRUCTION 00	(X3) DATE S COMPLI 08/04/2	ETED	
		155029	B. WINC			06/04/	2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  16TH ST		
COMMUNITY NURSING AND REHABILITATION CENTER					APOLIS, IN 46218		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	culture and sensi level) to be done level of conscious immediately.  The next nursing 5:25 p.m. by the indicated the fam wanted the reside hospital.  No laboratory regabove stat order or clinical record as Interview with the 8/2/11 at 11:45 a not arrived to draw before Resident I He indicated where a stat lab order, within four hours was recorded at I left the facility and four hours and for lab phlebotomist. The Director of N is located in north seems to depend staff are located to order is received is drawn. The indicated there warrangement made	ne Director of Nursing on .m. indicated the lab had aw the blood sample B went to the hospital. en their lab is notified of they come sometime s. In this case, the order 1:20 p.m. and the resident round 6 p.m., which was orty minutes later, and the had not yet arrived. Nursing indicated the lab th Indianapolis and it on how close their field to the facility when the as to how soon the blood e Director of Nursing ras no definite de with the laboratory		TAG	recur? The facility will obtain definitive agreement with the laboratory service regarding the time frame in which a laboratory service has not arritothe facility within 30 minutes the latest possible time the agreement says they will arrive the nurse will contact the Direct Business Development immediately. How the correct action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be printo place? The Lab CQI will reviewed monthly by the CQI Committee. Deficiency in this practice will result in disciplinate action up to and including termination of the responsible employee.	a ne pry he ved s of e, ctor ive b ut be	DATE
	arrangement mad						

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/04/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number:  155029	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMPLETED 08/04/2011			
	PROVIDER OR SUPPLIER NITY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  5600 E 16TH ST INDIANAPOLIS, IN 46218					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION			
	Review of the current contract with the laboratory on 8/4/11 at 11:50 a.m. indicated it did not specifically address the subject of orders for stat laboratory tests; therefore, a time frame had not been established.  This federal tag relates to complaint number IN00093656.  3.1-49(a)						

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